WRMA
Walter R. McDonald & Associates, Inc.

FINDINGS FROM THE

COMMUNITY FORUM for COUNTYWIDE POPULATIONS

CONDUCTED FOR THE MENTAL HEALTH SERVICES ACT
PREVENTION AND EARLY INTERVENTION PLAN
IN LOS ANGELES COUNTY

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We greatly appreciate the assistance we received from the LACDMH PEI staff, the Ad Hoc PEI Plan Development Advisory Group, Service Area Advisory Committees, and the Community Forum Coordinators in coordinating the forums. We also extend special thanks to all the community forum participants for taking the time to engage in the community forums and for sharing with us their perspectives. The wealth of information provided during each of the breakout session discussions was invaluable to the formation of this report.

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I. OVERVIEW

The Los Angeles County Department of Mental Health (LACDMH) is engaged in an intensive, inclusive, and multi-faceted approach to developing the County's Prevention and Early Intervention (PEI) Plan to be funded through the Mental Health Services Act (MHSA) enacted by California voters in 2004.

The primary focus for developing the PEI Plan is at the Service Area level, utilizing informational meetings, key individual interviews, focus groups, and community forums in each of the eight geographic areas of Los Angeles County. Because each Service Area has distinct and varying populations, geography, and resources, it is critical for PEI services to be specific and responsive to regional and community-based needs.

In addition, there are populations whose needs are best addressed through a countywide service delivery approach. LACDMH conducted a countywide community forum focused on American Indians; veterans; deaf and hard-of-hearing; lesbian/gay/bisexual/transgender/questioning (GLBTQ) individuals; countywide health plans; and juvenile justice-involved individuals.

PURPOSE. The community forums presented an exciting opportunity for community participants to make recommendations regarding priority populations and strategies for their communities that will help keep community members healthy.

This report presents the findings from the community forum conducted for countywide populations. The purpose of the countywide community forum was:

1. To introduce participants to the Department of Mental Health's Prevention and Early Intervention planning efforts.
2. To summarize what was learned from existing research, other community residents and service providers in this service area about needs, barriers and strategies for providing quality prevention and early intervention mental health services, and
3. To hear suggestions for where and to whom Prevention and Early Intervention services should be provided.

OUTCOMES. The countywide community forum had two specific outcomes:

1. To identify the priority populations to be served among specific countywide populations, including American Indians; veterans; deaf and hard-of-hearing; lesbian/gay/bisexual/transgender/questioning (GLBTQ) individuals; countywide health plans; and juvenile justice-involved individuals.
2. To develop recommendations for strategies to serve the priority populations selected for each specific population.

II. COMMUNITY FORUM METHODOLOGY

The community forum was designed to provide community members an additional opportunity to provide their input regarding priorities and strategies for addressing the six MHSA priority populations. With one exception (i.e., Service Area 1), a total of two community forums were held in each service area, for a total of 15 service area community forums. Each community forum was organized around age- and language-specific breakout sessions/groups for which community members registered in advance. In addition, one countywide forum was held that was organized around specific populations. Each community forum followed the same format and procedures.

PARTICIPANTS. Participants were community members interested in taking part in a discussion about the mental health service strategies that would most effectively address the mental health needs in their communities.

- To inform the public about the community forums, a concerted outreach effort to educate the public about the MHSA and the PEI planning process was conducted by Service Area and countywide. Outreach efforts also placed a large emphasis on encouraging community members to attend the community forums and provide their ideas and suggestions on effective ways to improve the social and emotional well-being of people in their communities.

- When interested community members registered to attend the countywide community forum, they elected to participate in one of the following six population-specific breakout sessions: 1) American Indians; 2) Veterans; 3) Deaf/hard-of-hearing; 4) Lesbian/gay/bisexual/transgender/questioning individuals; 5) Countywide health plans; and, 6) Juvenile justice-involved individuals. Each breakout session was comprised of no more than 35 participants.

- A total of 272 community members attended the countywide community forum and represented a diverse array of community sectors. Of the 272 participants, 32 percent represented mental health providers, 18 percent represented social services, 17 percent represented the underserved, 13 percent represented health, 14 percent represented consumers, and 10 percent represented education. Between less than 1 and 5 percent represented community family resource centers (5%), parents and families of consumers (4%), law enforcement (4%), employment (2%) and the media (<1%). Thirteen percent of participants did not indicate which sector they represented.

- A total of eleven population-specific breakout sessions were held across the countywide community forum. A breakdown of the number of community participants in each breakout session/group is presented in Table 1.

Table 1.
Countywide Community Forum Attendance by Population-Specific Breakout Group

Location	American Indians	Veterans	Deaf/Hard-of-hearing	LGBTQ	County-wide Health Plans	Juvenile Justice	Total
Los Angeles Convention Center	29	29	23	26	32	22	**161**
				19	26	22	**67**
						23	**23**
						21	**21**
Total by Group	**29**	**29**	**23**	**45**	**58**	**88**	**272**

FORMAT. The countywide community forum took place on a weekday over a period of three and one-half hours at the Los Angeles Convention Center. Translators were available for mono-lingual speakers of various languages. The agenda at the forum included: 1) A welcome from the PEI District Chief; 2) An introduction to the MHSA and Prevention and Early Intervention Plan; 3) An overview of the LACDMH needs assessment activities; 4) An orientation to population-specific data handouts; 5) Population-specific breakout groups/discussions; 6) Report-out on key findings from all breakout sessions; and 7) Final thoughts and acknowledgements from the District Chief.

BREAKOUT GROUPS. The breakout sessions/groups were conducted by facilitators representing LACDMH as a neutral third-party. Each breakout session/group was conducted by a team of two staff members from Walter R. McDonald & Associates, Inc. (WRMA) and their subcontractors, EvalCorp Research & Consulting, Inc., and Laura Valles and Associates, LLC. One team member facilitated the breakout session/group, while another served as scribe and recorded participants' responses on flip charts, which participants could refer to throughout the discussion. The emphasis of the breakout groups was on identifying the top priority populations to be served in the service area and the appropriate strategies for the community.

III. COUNTYWIDE SUMMARY

The countywide community forum was held on January 7, 2009, from 9:00 am to 12:30 pm at the Los Angeles Convention Center.

A total of 11 breakout sessions/groups were conducted at this community forum. Table 2 presents a summary of the top strategy each breakout session/group identified for the prioritized age groups and corresponding priority populations.

Table 2.
Summary of Breakout Groups' Priority Age and Priority Population Selections
(Number of votes/Number of participants in the breakout session or group)

AGE GROUP	PRIORITY POPULATION	PRIORITY STRATEGY
American Indians (1 Group, N=29)[1]		
Children 6 to15 (n=12.5)	Children and youth in stressed families (n=6)	Promotion of healthy youth development, including cultural, spiritual, physical, and emotional health (n=17)
Adults 26 to 59 (4.5/29)	Underserved cultural populations (17/29)	Utilization of the American Indian Center as a cross-training center; and, increased use of American Indian paraprofessionals and volunteers to reach geographically isolated community members, and to spearhead a movement towards greater awareness of wellness (n=9).
Veterans (1 Group, N=29)		
Transition-age Youth 16 to 25 (n=10)	Trauma-exposed (n=12)	Training on post-traumatic stress disorder (PTSD), brain trauma, and other forms of trauma (n=11).
Adults 26 to 59 (n=12)	Trauma-exposed (n=16)	Training, education, and outreach for veterans and their family members addressing life skills, job training, and system navigation; as well as training, education, and outreach for providers on treatment approaches (n=13).
Deaf/Hard-of-hearing (1 Group, N=23)[2]		
Children, 6 to 15 (n=8)	Children and youth in stressed families (n=11)	One-stop Center with well-trained staff, who are culturally and linguistically competent, who can provide culturally sensitive and relevant age-appropriate services to deaf and/or hard-of-hearing kids and their families, as well as to

[1] Voting dots placed on the line between two age groups were counted as half votes.
[2] This breakout group came to a consensus prior to the voting process for their top Priority Populations that persons who are deaf/hard-of-hearing constitute an Underserved Cultural Population. As a result, they decided to vote on the five remaining CDMH Priority Populations for each of their top two age groups.

		deaf and blind kids and their families, and/or deaf and developmentally disabled kids and their families. Centers would employ deaf and hard-of-hearing staff (including those with mental health issues) and be well-located geographically so that families would not have to travel far distances – at least one per Service Area. Staff also could provide home-based services for those who need them. Centers would fill gaps in existing services, and provide education support and/or therapists that go to schools. Centers would serve as a referral clearing house and refer out services which could not be provided on site. Services would be available based on need only, not depending on income, ability to pay, or other eligibility criteria. An additional component of these Centers is focused on the development of a mandate that requires criminal justice, education, medical/health, and other community based organization personnel to be informed and trained to effectively provide services to the Underserved Cultural Population of deaf/hard of hearing individuals and their families (n=23).
Transition-age Youth 16 to 25 (n=7)	Children and youth in stressed families (n=12)	One-stop Center with well-trained staff, who are culturally and linguistically competent, who can provide culturally sensitive and relevant age-appropriate services to deaf and hard of hearing kids and their families, as well as to deaf and blind kids and their families, and/or deaf and developmentally disabled kids and their families. Centers would employ deaf and hard of hearing staff (including those with mental health issues) and be well located geographically so that families would not have to travel far distances – at least 1 per Service Area. Staff also could provide home-based services for those who need them. Centers would fill gaps in existing services, and provide education support and/or therapists that go to schools. Specific life skills would be provided for TAY individuals (e.g., teaching them how to look/apply for jobs, supporting them in going to college, and informing them about the ADA, etc.). Centers would serve as a referral clearing house and refer out services which could not be provided on site. Services would be available based on need only, not depending on income, ability to pay, or other eligibility criteria. An additional component of these Centers is focused on the development of a mandate that requires criminal justice, education, medical/health, and other community based organization personnel to be informed and trained to effectively provide services to the Underserved Cultural Population of deaf and/or hard of hearing individuals and their families (n=23).

Gay/Lesbian/Bisexual/Transgender/Questioning (2 Groups, N=45)		
Children 6 to 15 (n=7/26)	Children and youth in stressed families (n=13/26)	Training and technical assistance regarding LGBTQ issues for school personnel, teachers, providers, community- and faith-based organizations, DPSS, DCFS, DMH and peer mentors using a strength-based approach, incentives, and culturally and linguistically appropriate materials (n=10/26).
Adults 26 to 59 (n=8/26)	Underserved cultural populations (n=16/26)	Integrated services that are provided by government and/or with community- and faith-based organizations that link mental health with social services, substance abuse services, primary care, HIV testing, and short-term supportive housing (n=10/26).
Transition-age Youth 16 to 25 (n=8/19)	Underserved cultural populations (n=9/19)	Peer-to-peer support groups and advocacy (n=7/19).
Adults, 26 to 59 (n=6/19)	Underserved cultural populations (n=9/19)	Stigma reduction by engaging faith-based organizations, using media, and programs in academic institutions (n=8/19).
Countywide Health Plans (2 Groups=58)		
Children, 6 to 15 (10/32)	Children and youth in stressed families (13/32)	School-based health clinics and PEI programs (11/32).
Transition-age Youth 16 to 25 (9/32)	Underserved cultural populations (13/32)	Increased access to PEI resources by utilizing modern technology (15/32).
Children 6 to 15 (5/26)	Children and youth in stressed families (16/26)	Countywide outreach strategies and public education programs (9/26).
Adults 26 to 59 (14/26)	Underserved cultural populations	A collaborative cross-system network of mental health, community, and faith-based providers and organizations (11/26).
Juvenile Justice (4 Groups=88)		
Children 6 to 15 (n=14/22)	Children and youth in stressed families (n=10/22)	Affordable and comprehensive PEI services in natural settings with cultural relevance, including transportation, literacy, translation services, after-school programs, and mentoring programs (n=12/22).
Transition-Age Youth 16 to 25 (n=8/22)	Children and youth at risk of or experiencing juvenile justice involvement (n=12/22)	Services for co-occurring disorders, alternative programs for at-risk youth, assistance for emancipated youth, a teen hotline, a mobile unit that offers counseling services, case management, legal free clinics, and more school counselors. Services need to be comprehensive with appropriate linkages and follow-up (n=10/22).

Children 6 to 15 (n=15/22)	Children and youth in stressed families (n=13/22)	Partnerships among DMH, school districts, and community-based organizations; as well as training for clinicians and educators (n=10/22).
Transition-Age Youth 16 to 25 (n=6/22)	Children and youth at risk of or experiencing juvenile justice involvement (n=9/22)	Greater support for community-based intervention programs and lower-level diversion programs within the court system instead of camps or jail (n=14/22).
Children 6 to 15 (n=12/23)	Children and youth at risk of or experiencing juvenile justice involvement (n=12/23)	Multiple prevention and early intervention services including, but not limited to, gang prevention, counseling, mentoring, skill-building classes, sports, etc., offered in friendly environments, such as, schools, after-school programs, community centers, community/faith-based organizations, parks and recreational centers, probation camps, and family resource centers with free transportation available (n=21/23).
Transition-age Youth 16 to 25 (n=10/23)	Children and youth at risk of or experiencing juvenile justice involvement (n=18/23)	Greater access to mental health services for youth prior to being released via Mental Health Courts (AB 2034 services). Services to include counseling and parenting classes for incarcerated youth with visits (family) based on successful program attendance (n=9/23).
Children 6 to 15 (n=12/21)	Children and youth in stressed families (n=10/21)	Work with whole families-of-origin, particularly with youth in foster care, residential treatment facilities, and incarcerated youth. This would include crisis intervention for witnesses of violence (i.e. sibling and caregivers) (n=7/21).
Transition-age Youth 16 to 25 (n=7/21)	Children and youth at risk of or experiencing juvenile justice involvement (n=15/21)	One-stop shop-based resource centers located in the community, schools, and courts, which would include diversionary approaches to working with youth as an alternative to incarceration and detention (n=11/21).

IV. TOP PRIORITY POPULATIONS SELECTED

After the facilitator introduced all the participants to the goals and focus of the breakout session/group, each participant was asked to vote on one of the five MHSA-identified age groups and then asked to vote on one of the six MHSA-identified priority populations under the top two voted age groups. Given the limited PEI resources, LACDMH requested the participants' assistance to identify which population within a specific age group needs to be a priority for the provision of PEI services and supports. Table 3 shows the age groups and the respective priority populations selected in the countywide population-specific breakout sessions.

In Table 3, each priority population selected under a specific age-group is indicated by the countywide specific population.[3]

Table 3. Top Two Priority Populations by Age Group

Priority Populations	Children, 0 to 5	Children, 6 to 15	Transition-age Youth, 16 to 25	Adults, 26 to 59	Older Adults, 60+
Underserved cultural populations			LGBTQ, CHP	AI, LGBTQ(2), CHP	
Individuals experiencing onset of serious psychiatric illness					
Children and youth in stressed families		AI, JJ(3), LGBTQ, CHP(2), D/HH	D/HH		
Trauma-exposed			V	V	
Children/youth at risk for school failure					
Children/youth at risk of or experiencing juvenile justice involvement		JJ	JJ(4)		

None of the breakout groups identified Children 0 to 5, or Older Adults 60+, as the top priority among the list of five groups they were asked to choose from. Among the nine groups selecting Children 6-15, eight of them considered Children and youth in stressed families a top priority: the American Indians group, the LGBTQ group, the Deaf/Hard-of-hearing group, three Juvenile Justice groups, and two Countywide Health Plan groups. One Juvenile Justice group also considered Children at risk of or experiencing juvenile justice involvement a priority among Children 6

[3] AI=American Indian; Veterans=V; Lesbian/Gay/Bisexual/Transgender/Questioning=LGBTQ; Deaf/Hard-of-hearing=D/HH; Countywide Health Plans=CHP; and, Juvenile Justice=JJ.

to 15. Among Transition-age Youth, one of two LGBTQ and Countywide Health Plans groups voted to address Underserved cultural populations; the Deaf/Hard-of-hearing group prioritized Children and youth in stressed families; the Veterans group voted to address the Trauma-exposed population; and all four of the Juvenile Justice breakout groups identified Children and youth at risk of or experiencing juvenile justice involvement as a top priority. With respect to Adults 26-59, the American Indian group, one Countywide Health Plans group, and two LGBTQ groups identified Underserved cultural populations as the priority population in most need of PEI services. In addition, the Veterans breakout session identified Trauma-exposed Adults 26 to 59 as a priority for PEI services.

V. RECOMMENDATIONS BY COUNTYWIDE BREAKOUT SESSIONS

The recommendations that emerged from the top age groups and priority populations selected in the breakout sessions/groups are presented below. Once each group had selected two age groups and their respective top priority populations, they were asked to drill deeper and list the sub-populations that fell under each priority population.

Participants also were asked to identify strategies for addressing the mental health needs of the age groups and priority populations selected. At the end of the discussion, the strategies were consolidated and each participant was given an opportunity to vote for one strategy under each age group and corresponding priority population. This section presents the top two to three strategies that emerged from those discussions as well as the sub-populations cited for each population by age group.

AMERICAN INDIANS

PRIORITY POPULATIONS. One countywide breakout session/group was conducted focusing on the mental health needs of American Indians. Table 4 presents the two age-groups and corresponding priority populations identified by this group. In addition, the table shows the number of participants in the group who voted for each priority population. In order to show the relative weight among the priority populations selected, the table includes the percentage of votes each priority population received in relation to the total number of participants in the group.

Table 4. Percentage of Participants Who Selected the Top Priority Populations for American Indians

Age Group	Top Priority Populations Selected	# of Groups	# Votes Received	Total # of Participants	Percentage of Votes Received
Children, 6-15	Children and youth in stressed families	1	12	29	41%
Adults, 26-59	Underserved cultural populations	1	17	29	59%

SUB-POPULATIONS. Table 5 displays how participants defined the sub-populations for Children and youth, 6 to 15, in stressed families and for Underserved cultural populations among Adults 26 to 59.

Table 5. Priority Population Sub-populations for American Indians (N=29)

Priority Populations	American Indian Sub-populations
	Children, 6 to 15
Children and Youth in Stressed Families	• Homeless children; children from low-income families; single-parent families; and, children in multi-generation homes. • Children who are depressed; and, children exploring their sexual orientation. • Children who are in foster care; and, adopted children. • Children from multi-racial families; and children with a language barrier. • Indian Child Welfare Act (ICWA)-impacted families; and, families and children who are isolated from their cultural identity. • Geographically isolated families; and, children with transportation barriers. • Children in families with domestic violence; families impacted by substance abuse; and, families impacted by depression. • Children with a lack of information and resources; and children with limited access to culturally relevant health care.
	Adults, 26 to 59
Underserved Cultural Populations	• American Indian community; American Indian women; Alaskan Native population; Native Hawaiian population; indigenous speaking populations from south of the U.S. border; and, migratory populations from reservations to city. • Homeless; veterans; extended families; and, college students. • Two-spirit, lesbian, gay, bisexual, transgender and questioning individuals. • Persons experiencing domestic violence; those with substance abuse problems; and, those with co-occurring disorders. • People grappling with acculturation, especially movement between urban and rural environments.

STRATEGIES. The two to three top strategies selected by the American Indians breakout session/group are presented by age group and priority population in Table 6.

Table 6. Top Strategies by Age Group and Priority Population for American Indians (N=29)

Age Group	Priority Populations	Strategy #1	Strategy #2	Strategy #3
Children, 6 to 15	**Children and Youth in Stressed Families**	Promotion of healthy youth development, including cultural, spiritual, physical, and emotional health (n=17).	Department of Mental Health and Diagnostic and Statistical Manual of Mental Health Disorders understanding, acceptance, and use of American Indian traditional practices. Also, ensure adequate identification and referrals of Native clients (n=6).	Increased efficiency of outreach to Native American Indian families, including the use of satellite offices and public information campaigns (n=1).
Adults, 26 to 59	**Trauma-exposed**	Utilization of the American Indian Center as a cross-training center; and, increased use of American Indian paraprofessionals and volunteers to reach geographically isolated community members, and to spearhead a movement towards greater awareness of wellness (n=9).	Utilization of traditional healing practices in supporting wellness (Native American Church, ceremonies, etc.) (n=7).	More cultural centers, wellness centers, and recovery centers (n=5).

VETERANS

PRIORITY POPULATIONS. One countywide breakout session/group was conducted focusing on the mental health needs of Veterans. Table 7 presents the two age-groups and corresponding priority populations identified by this group. In addition, the table shows the number of participants in the group who voted for each priority population. In order to show the relative weight among the priority populations selected, the table includes the percentage of votes each priority population received in relation to the total number of participants in the group.

Table 7. Percentage of Participants Who Selected the Top Priority Populations for Veterans

Age Group	Top Priority Populations Selected	# of Groups	# Votes Received	Total # of Participants	Percentage of Votes Received
Transition-age Youth, 16 to 25	Trauma-exposed	1	12	29	41%
Adults, 26-59	Trauma-exposed	1	16	29	55%

SUB-POPULATIONS. Table 8 displays how participants defined the sub-populations for Trauma-exposed individuals among Transition-age Youth 16 to 26 and Adults 26 to 59.

Table 8. Priority Population Sub-populations for Veterans (N=29)

Priority Populations	Veterans Sub-populations
	Transition-age Youth, 16 to 25
Trauma-exposed	• Same sub-populations as listed for adults. • Veterans aged 21-22; White, Hispanic, and, young veterans with major trauma; and, women veterans who are sexually discriminated against or experience sexual trauma. • Those who are part of the internet/technology generation; and, those who are not college educated. • Those who need to re-establish relationships with family members, peers; and those who need more family connections or to establish close connections. • Those with a history of substance abuse; and, those who have experienced multiple traumas (e.g., substance abuse and injury). • Those who are dishonorably discharged or honorably discharged but had a prior history of mental health issues before going into combat.
	Adults, 26 to 59
Trauma-exposed	• Young Hispanics; women; single; prisoners of war; guards/reservists; those not in the VA system; those who have been to war and back; and, homeless. • Those with traumatic brain injury; PTSD; adjustment disorder; combat depression; severe depression and suicide; co-occurring diagnosis/substance abuse; and, history of prior mental illness. • Those with family reintegration issues; and, those released from the criminal justice system. • Those experiencing financial stress; those who return from service and are unemployed; those experiencing marital stress; and, those exposed to domestic violence. • Those who cannot or will not access services.

STRATEGIES. The two to three top strategies selected by the Veterans breakout session/group are presented by age group and priority population in Table 9.

Table 9. Top Strategies by Age Group and Priority Population for Veterans (N=29)

Age Group	Priority Populations	Strategy #1	Strategy #2	Strategy #3
Transition-age Youth, 16 to 25	**Trauma-exposed**	Training on post-traumatic stress disorder (PTSD), brain trauma, and other forms of trauma (n=11).	Training, education, outreach for veterans, and family members on services, resources, and programs (n=7).	Peer-based programs that provide housing, outreach, education, and other services (n=3).
Adults, 26 to 59	**Trauma-exposed**	Training, education, and outreach for veterans and their family members addressing life skills, job training, system navigation, among others; as well as training, education, and outreach for providers on treatment approaches (n=13).	More cross-system collaboration between DMH, the Veteran's Administration, and other systems (n=7).	More wellness centers and/or peer operation clinics (n=2).

DEAF/HARD-OF-HEARING

PRIORITY POPULATIONS. One countywide breakout session/group was conducted focusing on the mental health needs of the Deaf and Hard-of-hearing. Table 10 presents the two age groups and corresponding priority populations identified by this group. Again, this group came to consensus that the Deaf/Hard-of-hearing are already a defined Underserved cultural population and their voting process selected Children and youth in stressed families from the remaining five Priority Populations for each top-voted age group. Table 10 also shows the number of participants in the group who voted for each priority population. In order to show the relative weight among the priority populations selected, the table includes the percentage of votes each priority population received in relation to the total number of participants in the group.

Table 10. Percentage of Participants Who Selected the Top Priority Populations for the Deaf/Hard-of-hearing

Age Group	Top Priority Populations Selected	# of Groups	# Votes Received	Total # of Participants	Percentage of Votes Received
Children, 6 to 15	Children and youth in stressed families	1	11	23	48%
Transition-age Youth, 16 to 25	Children and youth in stressed families	1	12	23	52%

SUB-POPULATIONS. Table 11 displays how participants defined the sub-populations for Children and youth in stressed families among Children 6 to 15 and Transition-age Youth 16 to 26.

Table 11. Priority Population Sub-populations for the Deaf/Hard-of-hearing (N=23)

Priority Populations	Deaf/Hard-of-hearing Sub-populations
	Children, 6 to 15
Trauma-exposed	• All children who are deaf/HH living in a family that is stressed; and, hearing kids who have deaf parents. • Families who are tri-lingual (English, ASL and another language); low income families; undocumented children and their families; and, families that lack health insurance. • Families that lack education about the deaf community/deaf culture; and, families that are unaware of services/resources that are available for deaf children or those with hearing loss. • Deaf/HH children/youth that have been sexually and/or physically abused; children who experience secondary abuse because of domestic/family violence and/or alcohol or drug abuse; and, deaf/HH children experiencing stigma and discrimination, which lowers their self esteem. • Children who are misdiagnosed as having a behavioral problem; deaf children who fall behind at school and experience withdrawal symptoms; and, families who have a child that is deaf/HH and also has other challenges (e.g., autism). • Children/youth that are hard of hearing, but not deaf; children with cochlear implants; and, identity issues that arise among kids with cochlear implants. • Families that see deafness as only a medical problem, and do not recognize or are unaware of the social and cultural aspects associated with it.
	Transition-age Youth, 16 to 25
Trauma-exposed	• All of the subpopulations listed for Children 6-15. • Deaf/HH TAY with stressed or nonexistent peer relations; and, deaf/HH TAY who lack people in their life who can help them. • Deaf/HH TAY trying to find acceptance; deaf/HH TAY experiencing isolation as a result of not being able to communicate with the mainstream – often feeling as though they do not have what they need to succeed in life, then become dependent on others or SSI because they cannot get jobs; TAY experiencing difficulty as there are few jobs that may be available to those who are deaf/HH; deaf/HH TAY challenged by leaving Special Ed, are entering college or trying to enter the workplace. • Deaf/HH TAY who lack life/other skills necessary to navigate through adulthood; and, deaf/HH TAY who are transitioning into

	adulthood with a lack of preparedness. • Deaf/HH TAY who are self medicating with drugs or alcohol • Deaf/HH TAY whose parents are in denial about their children; deaf/HH TAY and their families who are not knowledgeable about ADA laws; lack of deaf role models contributes to stress experienced by deaf/HH TAY • Deaf/HH TAY and their families experiencing challenges and stress due to being misinterpreted – providers often misinterpret needs; and, miscommunication or misinformation that deaf/HH TAY receive from their peers • Families who do not recognize mental health issues/problems; deaf/HH TAY who are beginning to experience mental health symptoms and are misdiagnosed as having behavioral problems; deaf/HH TAY who have medical problems and/or are on medication which adds to existing stressors. • Families with very high expectations that deaf/HH TAY may not be able to meet. • TAY who are raised orally, have cochlear implants and are resentful, or are experiencing feeling left out and/or have identity issues.

STRATEGIES. The two to three top strategies selected by the Deaf/Hard-of-hearing breakout session/group are presented by age group and priority population in Table 12.

Table 12. Top Strategies by Age Group and Priority Population for Deaf/Hard-of-hearing (N=23)

Age Group	Priority Populations	Strategy #1	Strategy #2	Strategy #3
Children, 6 to 15	**Children and Youth in Stressed Families**	One-stop Center with well-trained staff, who are culturally and linguistically competent, who can provide culturally sensitive and relevant age-appropriate services to deaf and/or hard-of-hearing kids and their families, as well as to deaf and blind kids and their families, and/or deaf and developmentally disabled kids and their families. Centers would employ deaf and hard of hearing staff (including those with mental health issues) and be well located geographically so that families would not have to travel far distances – at least one per Service Area. Staff also could provide home-based services for those who need them. Centers would fill gaps in existing services, and provide education support and/or therapists that go to schools. Centers would serve as a referral clearing house and refer out services which could not be provided on site. Services would be available based on need only, not depending on income, ability to pay, or other eligibility criteria. An additional component of these Centers is focused on the development of a mandate that requires criminal justice, education, medical/health, and other community based organization personnel to be informed and trained to effectively provide services to the Underserved Cultural Population of deaf/hard-of-hearing individuals and their families (n=23).	No other strategy was elected. All participants voted for Strategy #1.	No other strategy was elected. All participants voted for Strategy #1.

Table 12. Top Strategies by Age Group and Priority Population for Deaf/Hard-of-hearing (N=23)

Age Group	Priority Populations	Strategy #1	Strategy #2	Strategy #3
Transition-age Youth, 16 to 25	**Children and Youth in Stressed Families**	One-stop Center with well-trained staff, who are culturally and linguistically competent, who can provide culturally sensitive and relevant age-appropriate services to deaf and hard-of-hearing kids and their families, as well as to deaf and blind kids and their families, and/or deaf and developmentally disabled kids and their families. Centers would employ deaf and hard of hearing staff (including those with mental health issues) and be well located geographically so that families would not have to travel far distances – at least one per Service Area. Staff also could provide home-based services for those who need them. Centers would fill gaps in existing services, and provide education support and/or therapists that go to schools. Specific life skills would be provided for TAY individuals (e.g., teaching them how to look/apply for jobs, supporting them in going to college, and informing them about the ADA, etc.). Centers would serve as a referral clearing house and refer out services which could not be provided on site. Services would be available based on need only, not depending on income, ability to pay, or other eligibility criteria. An additional component of these Centers is focused on the development of a mandate that requires criminal justice, education, medical/health, and other community based organization personnel to be informed and trained to effectively provide services to the Underserved Cultural Population of deaf and/or hard-of-hearing individuals and their families (n=23).	No other strategy was elected.	No other strategy was elected.

LESBIAN/GAY/BISEXUAL/TRANSGENDER/QUESTIONING (LGBTQ)

PRIORITY POPULATIONS. Two breakout sessions/groups were conducted focusing on the mental health needs of the LGBTQ community. Table 13 presents the three age groups and corresponding priority populations identified by these two groups. In addition, the table shows the number of participants in the groups who voted for each priority population. In order to show the relative weight among the priority populations selected, the table includes the percentage of votes each priority population received in relation to the total number of participants in the group.

Table 13. Percentage of Participants Who Selected the Top Priority Populations for LGBTQ Individuals

Age Group	Top Priority Populations Selected	# of Groups	# Votes Received	Total # of Participants	Percentage of Votes Received
Transition-age Youth, 16 to 25	Underserved cultural populations	1	9	19	47%
Children, 6 to 15	Children and youth in stressed families	1	13	26	50%
Adults, 26 to 59	Underserved cultural populations	2	25	45	56%

SUB-POPULATIONS. Table 14 displays how those in the LGBTQ breakout sessions/groups defined the sub-populations for Children and youth in stressed families among Children 6 to 15, and Underserved cultural populations among Transition-age youth 16 to 25 and Adults 26-59.

Table 14. Priority Population Sub-populations for LGBTQ Individuals

Priority Populations	LGBTQ Sub-populations	
	Children, 6 to 15 (N=26)	
Children and Youth in Stressed Families	• LGBTQ foster children; LGBTQ runaways; and, developmentally challenged children. • LGBTQ African American, Latino, and Armenian children; Latino children of alcoholics; and, students who are bullied. • Children raised by same sex couples; children with both parents working; and, LGBTQ children and youth living in immigrant households. • Children living in homes with domestic violence; sexually abused children; and, youth experiencing dating violence. • Children and youth with crystal meth addictions; and, LGBTQ youth at-risk for HIV. • LGBTQ youth in strong faith-based communities. • Children questioning their gender; LGBTQ children coming out to their families; and, children experiencing parental rejection.	
	Transition-age Youth, 16 to 25 (N=19)	
Underserved Cultural Populations	• African American, Latino, Native American, and Asian youth. • Junior high, high school and colleges students; individuals coming out; LGBTQ immigrants; and, transgender/gender variance. • Youth using, abusing, and/or addicted to substances; youth who are HIV positive/ negative; and, homeless youth with mental illness. • Youth with LGBTQ parents. • Youth in the system as foster care or group home youth.	
	Adults, 26 to 59 (N=45)	
	Group 1 (N=26)	**Group 2 (N=19)**
Underserved Cultural Populations	• Asian Pacific MSM, transgender, and questioning men; Latino men having sex with men and women; straight men having sex with men (MSM); closeted African Americans and Armenians; and, lesbians, especially closeted Latino women. • Individuals with HIV or impacted by HIV, especially persons of color; and, long-term AIDS survivors.	• African American, Latino, Native American, and Asian adults. • Monolingual adults; transgender/ gender variant; and, adults previously in heterosexual marriages. • HIV positive/ negative exposed; and, survivors of 80's AIDS. • Adults using and/or abusing substances; adults who experience domestic violence; and, adults who are homeless and have a mental illness.

Table 14. Priority Population Sub-populations for LGBTQ Individuals

	LGBTQ Sub-populations	
	• Substance abusers; individuals impacted by domestic violence, including victims, abusers, and adults who grew up with domestic violence; and, incarcerated LGBTQ individuals. • Immigrants and undocumented individuals, especially limited- or non-English speaking; homeless; sex workers; adult children of alcoholics; and, LGBTQ individuals involved with faith-based organizations. • Individuals with physical and developmental disabilities, especially those living together in group homes.	• Individuals in their 50's who experience loss and/or grief; and, individuals in their 50's who experience care giving.

STRATEGIES. The two to three top strategies selected by the LGBTQ breakout sessions/groups are presented by age group and priority population in Table 15.

Table 15. Top Strategies by Age Group and Priority Population for LGBTQ Individuals

Age Group	Priority Populations	Group	Strategy #1	Strategy #2	Strategy #3
Children, 6 to 15	**Children and Youth in Stressed Families**	1 (N=26)	Training and technical assistance regarding LGBTQ issues for school personnel, teachers, providers, community- and faith-based organizations, DPSS, DCFS, DMH and peer mentors using a strength-based approach, incentives, and culturally and linguistically appropriate materials (n=10).	Increased school mental health programs, after school programs, peer programs, and integrated services for LGBTQ children and families (n=9).	A variety of therapies to overcome domestic violence, such as art, music, writing and play therapy (n=2).
Transition-age Youth, 16 to 25	**Underserved Cultural Populations**	2 (N=19)	Peer to peer support groups and advocacy (n=7).	Education on LGBTQ issues for the psychiatric sectors, police departments, and jail service providers (n=5).	Strategy not identified.
Adults, 25 to 59	**Underserved Cultural Populations**	1 (N=26)	Integrated services that are provided by government and/or with community- and faith-based organizations that link mental health with social services, substance abuse services, primary care, HIV testing, and short-term supportive housing (n=10).	Culturally and linguistically appropriate training and technical assistance for providers, faith- and community-based organizations, school personnel, and peer bridges regarding LGBTQ and mental health issues (n=5).	Cultural and language-specific services and materials for LGBTQ underserved cultural populations such as African Americans, Latinos, Asian Pacific Islanders and Armenians (n=3).
		2 (N=19)	Stigma reduction by engaging faith-based organizations, using media, and programs in academic institutions (n=8).	Effective culturally sensitive educational trainings for all providers on specific needs of the LGBTQ population (n=5).	Expanded safe environments for youth and parents in all Service Areas with access to resources, support, and drug free social activities (n=5).

COUNTYWIDE HEALTH PLANS

PRIORITY POPULATIONS. Two breakout sessions/groups were conducted focusing on the mental health needs of Countywide Health Plans. Table 16 presents the three age groups and corresponding priority populations identified by these two groups. In addition, the table shows the number of participants in the groups who voted for each priority population. In order to show the relative weight among the priority populations selected, the table includes the percentage of votes each priority population received in relation to the total number of participants in the group.

Table 16. Percentage of Participants Who Selected the Top Priority Populations for Countywide Health Plans

Age Group	Top Priority Populations Selected	# of Groups	# Votes Received	Total # of Participants	Percentage of Votes Received
Transition-age Youth, 16 to 25	Underserved cultural populations	1	13	32	41%
Children, 6 to 15	Children and youth in stressed families	2	29	58	50%
Adults, 26 to 59	Underserved cultural populations	1	14	26	54%

SUB-POPULATIONS. Table 17 displays how those in the Countywide Health Plans breakout sessions/groups defined the sub-populations for Children and youth in stressed families among Children 6 to 15, and Underserved cultural populations among Transition-age youth 16 to 25 and Adults 26-59.

Table 17. Priority Population Sub-populations for Countywide Health Plans

Priority Populations	Countywide Health Plans Sub-populations	
	Children, 6 to 15	
	Group 1 (N=32)	Group 2 (N=26)
Children and Youth in Stressed Families	• Children who are the responsibility of the state (foster care, probation system). • Children exposed to peer pressure from community, gangs, etc.; those overwhelmed by stressful or traumatic events; and, children who are unable to cope with stressors and lack access to resources. • Children who experience academic failure (their grades have dropped). • Children experimenting with substances because of exposure to violence.	• Trauma-exposed. • School-aged children. • Children in foster care. • Children involved with gangs.
	Transition-age Youth, 16 to 25 (N=32)	
Underserved Cultural Populations	• Homeless; and, the welfare community. • Gay, lesbian, bisexual, transgender and questioning adolescents and adults. • Those who have experienced inequality or injustice. • Individuals with language limitations; and, 1st and 2nd generation youth trying to deal with cultural differences and unrealistic academic expectations. • Youth dealing with mental illnesses and who are self-medicating by using drug. • Individuals who have neighborhood/geographical limitations to accessing resources; and, those lacking access to culturally competent resources.	
	Adults, 26 to 59 (N=26)	
Underserved Cultural Populations	• Homeless. • Board and care residents. • Medi-Cal recipients. • The uninsured. • People already in the mental health system.	

STRATEGIES. The two to three top strategies selected by the Countywide Health Plans breakout sessions are presented by age group and priority population in Table 18.

Table 18. Top Strategies by Age Group and Priority Population for Countywide Health Plans

Age Group	Priority Populations	Group	Strategy #1	Strategy #2	Strategy #3
Children, 6 to 15	**Children and Youth in Stressed Families**	1 (N=32)	School-based health clinics and PEI programs (n=11).	Family-focused intervention programs (n=10).	Strategy not identified.
		2 (N=26)	Countywide outreach strategies and public education programs (n=9).	Partnerships with community based clinics and primary care physicians and providers (n=8).	Education and training for parents and educators (n=5).
Transition-age Youth, 16 to 25	**Underserved Cultural Populations**	1 (N=32)	Increased access to PEI resources by utilizing modern technology (n=15).	PEI programs for people who have co-occurring disorders (n=4).	Strategy not identified.
Adults, 25 to 59	**Underserved Cultural Populations**	2 (N=26)	A collaborative cross-network system of mental health, community, and faith-based providers and organizations (n=11).	A community-based non-traditional network of services (n=6).	Available culturally and linguistically diverse services (n=4).

JUVENILE JUSTICE

PRIORITY POPULATIONS. Four breakout sessions/groups were conducted focusing on the mental health needs of individuals experiencing juvenile justice involvement. Table 19 presents the two age groups and corresponding priority populations identified by these four groups. In addition, the table shows the number of participants in the groups who voted for each priority population. In order to show the relative weight among the priority populations selected, the table includes the percentage of votes each priority population received in relation to the total number of participants in the group.

Table 19. Percentage of Participants Who Selected the Top Priority Populations for Juvenile Justice-involved Individuals

Age Group	Top Priority Populations Selected	# of Groups	# Votes Received	Total # of Participants	Percentage of Votes Received
Children, 6 to 15	Children and youth in stressed families	3	33	65	51%
Children, 6 to 15	Children and youth at risk of or experiencing juvenile justice involvement	1	12	23	52%
Transition-age Youth, 16 to 25	Children and youth at risk of or experiencing juvenile justice involvement	4	54	88	61%

SUB-POPULATIONS. Table 20 displays how those in the Juvenile Justice breakout sessions/groups defined the sub-populations for Children and youth in stressed families among Children 6 to 15, and Children and youth at risk of or experiencing juvenile justice involvement among Children 6 to 15 and Transition-age youth 16 to 25.

Table 20. Priority Population Sub-populations for Juvenile Justice-involved Individuals

Priority Populations	Juvenile Justice Sub-populations		
	Children, 6 to 15		
	Group 1 (N=22)	Group 2 (N=22)	Group 4 (N=21)
Children and Youth in Stressed Families	• Children involved in gangs or with criminal activity; children exposed to domestic violence; children exposed to community violence; and, children who have been sexually abused. • Children whose parents are English language learners; and, immigrant children. • Children in foster care; children raised by non-biological caretakers; and, children in single parent homes. • Children of incarcerated or deported parents; children of separated parents and who are separated from their parents; and, disjointed families.	• Black and Latino males; teen parents; children in foster care; and, recently arrived immigrants. • Children suffering from the death or loss of family or community members; children who find a need to be over achievers; and, children without access to adequate health care. • Children living in low-income environment or single parent households; children in families living in crowded conditions and special circumstances; children living in gang infested neighborhoods; and, children with generational gang involvement. • Children in families who have mental illness, or are exposed to families with mental illness, or are neglected by families with mental illness; and, parents with substance abuse or mental health diagnoses. • Children who are perpetrators or victims of sexual abuse; children living in homes where there is domestic violence and substance abuse; children who are abused physically, emotionally or psychologically; and, sibling violence.	• Children who are incarcerated; children placed in foster care; and, younger siblings of older siblings in "systems" (i.e. juvenile justice, foster care, etc). • Children living with family members who have mental health issues or other health issues; children with drug and alcohol abuse in the home; and, children who are victims of emotional or physical abuse. • Children of teen parents; children of older parents; children being raised by grandparents; immigrant children living with extended family or undocumented family; and, children of incarcerated parents. • Children living in extreme poverty and/or living with multiple families in a single dwelling; children living in homes with illiteracy; and, children living in homes where other family members may have disabilities. • Children of parents with poor parenting skills; children of parents who cannot distinguish between behavior problems and the onset of mental health issues.

Table 20. Priority Population Sub-populations for Juvenile Justice-involved Individuals

	Juvenile Justice Sub-populations			
	• Children and youth exposed to substance abuse; and, children living with parents with co-occurring disorders.	• Children with parents or siblings who are incarcerated or otherwise involved in the legal system (e.g., on probation); children living with hostile custody conditions (parents who are unmarried, divorced or separated); children who initiate separation from family or care givers through legal means. • Latchkey kids; children living with lack of caring supervision; and, children living with parents who have little or no parenting skills.		
	Group 3 (N=23)			
Children and Youth at risk of or Experiencing Juvenile Justice Involvement	• Runaways; gang-involved individuals, including taggers, skate-boarders; foster youth; teen parents; at-risk children; children in unsafe communities; and, lower SES children. • Children with incarcerated parents; children in single-parent homes; children of teen parents; and, children raised by grandparents or other relatives. • Substance abusing children or their parents; at-risk children with severe mental illness; physically and sexually abused children; and, trauma-exposed children. • Latchkey children; and, children living in homes without positive role models. • Children failing in school; children known as having poor school performance (i.e., African American youth; and, special needs children with developmental delays or learning disabilities). • Children who bully; and, children who are bullied.			
	Transition-age Youth, 16 to 25			
	Group 1 (N=22)	Group 2 (N=22)	Group 3 (N=23)	Group 4 (N=21)
Children and Youth at risk of or Experiencing Juvenile Justice Involvement	• Homeless youth; school drop outs; pregnant youth; single parents; LGBTQ youth; and, uninsured youth. • Children with academic behavioral problems in	• Graduating high school seniors or college students; unemployed youth 18 and older; youth in probation camps; recently arrived immigrants; unaccompanied minor immigrants; teen parents; youth in residential care; youth involved in relationships; chronic runaways; homeless; drug users; undocumented	• Homeless youth (i.e., youth without access to affordable housing); and, youth in placement or multiple placements with nowhere to go,	• Foster care youth; undocumented youth; and, siblings of youth in residential treatment. • Youth of

Table 20. Priority Population Sub-populations for Juvenile Justice-involved Individuals

	Juvenile Justice Sub-populations			
	school; and, youth who are not receiving adequate academic attention. • Youth lacking job skills; youth with low self-esteem; and, unemployed TAY who are out of school. • Foster youth who are or close to emancipation; foster youth in multiple placements with attachment issues; and, youth in unsupervised group homes. • TAY lacking appropriate role models; TAY in abusive relationships; TAY exposed to trauma; and, TAY involved with gangs.	population; youth 18 and older applying for General Relief (GR), CalWORKS, Food Stamps; youth 18 and older whose parents cannot provide care; and, youth with developmental delays. • Black and Latino males; African American and Latino male dropouts or who are struggling in school; and, LGBTQ youth with gender issues. • Children in families living in crowded conditions and special circumstances; children living in gang infested neighborhoods; children living in low-income environments or single parent households; and, children in foster care or exposed to substance abuse. • Children exhibiting high-risk behaviors such as drug abuse, violence; and, children with generational gang involvement. • Children in families who have mental illness, are exposed to families with mental illness, or are neglected by families with mental illness; and, parents with substance abuse or mental health diagnoses. • Children who are perpetrators or victims of sexual abuse; children living in homes with domestic violence and substance abuse; children who are abused physically, emotionally or psychologically; sibling violence; and, trauma-exposed leading to incarceration. • Children living with hostile custody conditions (parents are unmarried, divorced or separated); children who initiate separation from family or care givers through legal means; and, children	includes foster youth and those in juvenile hall. • Throwaway youth; new adults at 18+, including emancipated youth; teen parents; impoverished youth; undocumented youth; gang-involved youth; unemployed youth; youth who lack job skills; youth who are on probation or suspension; and, youth in camps who lack pro-social skills. • Substance abusing youth or their parents; youth who self-harm, are at-risk of suicide, or are hospitalized; mentally ill youth with limited or no medical care; youth who lack mental health services in juvenile camps; and, youth showing early signs of a mental illness. • Youth with excessive suspensions,	immigrant families with parents who are unable to participate in their children's education; youth part of multi-generational gang-affiliated families; and, youth of incarcerated parents. • Youth experiencing truancy, suspensions, expulsions or drop outs; and, youth with nothing to do (i.e. community either does not have the extra-curricular activities or youth can't get to them due to transportation or gang territories). • Youth experiencing substance abuse

Table 20. Priority Population Sub-populations for Juvenile Justice-involved Individuals

	Juvenile Justice Sub-populations			
		with parents or siblings who are incarcerated or otherwise involved in the legal system (e.g., on probation). • Latchkey kids; children living with lack of caring supervision; children living with parents who have little or no parenting skills; and, youth with no one to mentor them. • Children suffering from the death or loss in family or community; children who find a need to be over achievers; and, youth 18-25 who are not politically active (lack of initiative). • Children without access to adequate health care; and, youth with terminal illness (cancer, HIV). • Youth transitioning out of foster care with no family; teen or young parents who need to transition back to their children; institutionalized youth needing to be transitioned back to their homes; youth with mental health issues transitioning from Early Periodic Screening (EPS); and, youth with felonies and transitioning back to society.	expulsions, or behavior issues; youth who bully; and, youth who are bullied. • Youth with family members who are involved with the criminal justice system; and, youth who have no appropriate adult role models.	(multiple substances); youth experiencing onset of mental illness; non-diagnosed youth in "systems" (i.e. foster care, juvenile justice); and, non-diagnosed or misdiagnosed youth.

STRATEGIES. The two to three top strategies selected by the Juvenile Justice breakout sessions/groups are presented by age group and priority population in Table 21.

Table 21. Top Strategies by Age Group and Priority Population for Juvenile Justice-involved Individuals

Age Group	Priority Populations	Group	Strategy #1	Strategy #2	Strategy #3
Children, 6 to 15	**Children and Youth in Stressed Families**	1 (N=22)	Affordable and comprehensive PEI services in natural settings with cultural relevance, including transportation, literacy, translation services, after-school programs, and mentoring programs (n=12).	Outreach and education with cultural relevance that includes media, internet, and information fairs for children and families (n=3).	Development of specific programs to increase child, youth and families coping skills (i.e., mentoring, anger management, and self-esteem workshops) (n=5).
		2 (N=22)	Partnerships among DMH, school districts, and community-based organizations; and, training for clinicians and educators (n=10).	Incorporation of DMH facilitators into the community along with the provision of flex funds for childcare and transportation to get parents to come to group sessions (n=4).	Strategy not identified.
		4 (N=21)	Work with whole families-of-origin, particularly with youth in foster care, residential treatment facilities, and incarcerated youth. This would include crisis intervention for witnesses of violence (i.e. sibling and caregivers) (n=7).	Increased pro-social recreational activities for young people that strengthen protective factors (anger management, coping skills) in communities and schools (places where children already are at) (n=7).	Increased school capacity to address and respond to mental health issues, such as the provision of mental health services; recognition of warning signs or other risk factors (i.e., poor academic performance), increased number of clinicians affiliated at schools, and increased partnerships with mental health community-based providers (n=4).
	Children and Youth at-risk of or Experiencing Juvenile	3 (N=23)	Multiple prevention and early intervention services including, but not limited to, gang prevention, counseling, mentoring, skill-building classes, sports, etc., offered in	No other strategy was elected.	No other strategy was elected.

Table 21. Top Strategies by Age Group and Priority Population for Juvenile Justice-involved Individuals

Age Group	Priority Populations	Group	Strategy #1	Strategy #2	Strategy #3
	Justice Involvement		friendly environments such as schools, after-school programs, community centers, community and/or faith-based organizations, parks and recreational centers, probation camps, and, family resource centers with free transportation available (n=21).		
Transition-age Youth, 16 to 25	**Children and Youth at risk of or Experiencing Juvenile Justice Involvement**	1 (N=22)	Services for co-occurring disorders, alternative programs for at-risk youth, assistance for emancipated youth, teen hotline, mobile unit that offers counseling services, case management, legal free clinics, and more school counselors. Services need to be comprehensive with appropriate linkages and follow-up (n=10).	Education and training for parents on the risks of Internet use, problem solving skills, privacy rights, youth legal rights, nutrition, and job training. Training/education needs to be linguistically appropriate, and facilitated using a peer advocate model (n=9).	Improved collaboration between private and non-private organizations to better service families (n=1).
		2 (N=22	Greater support for community-based intervention programs and lower-level diversion programs within the court system instead of camps or jail (n=14).	Liaisons at school sites (e.g., law enforcement, DMH, and, Educator Advocate) as well as DMH presence in jails and camps (n=4).	Strategy not identified.
		3 (N=23)	Greater access to mental health services for youth prior to being released via Mental Health Courts (AB 2034 services). Services to include counseling and parenting classes for incarcerated youth with visits (family) based on successful program attendance (n=9).	Multiple PEI services including, but not limited to, gang prevention, counseling, mentoring, skill-building classes, sports, etc., offered in friendly environments such as schools, after-school programs, community centers, community/faith-based	Strategy not identified.

Table 21. Top Strategies by Age Group and Priority Population for Juvenile Justice-involved Individuals

Age Group	Priority Populations	Group	Strategy #1	Strategy #2	Strategy #3
				organizations, parks and recreational centers, probation camps, and family resource centers with free transportation available (n=7).	
		4 (N=21)	One-stop shop resource centers located in community, schools, courts, which would include diversionary approaches to working with youth as an alternative to incarceration and detention (n=11).	Extensive and comprehensive life skills and prevention education for at-risk youth (gang affiliated, TAY, siblings, and foster youth) (n=6).	Universal/blanket screenings for youth at-risk (n=2).

VI. RECOMMENDATIONS FOR ADDITIONAL NEEDS OR POPULATIONS

At the end of each breakout session, participants were asked to identify any additional needs or populations that were not addressed during the discussion around priority population strategies. The suggestions offered are presented below.

ADDITIONAL NEEDS OR POPULATIONS	
American Indians	Additional Comment: A majority of the homeless women and kids have experienced domestic violence, especially those with children. Use strategies to ensure shelter is available, which includes culturally relevant counseling to provide early intervention to reduce symptoms of post traumatic stress disorder for both women and children.
Veterans	• None provided.
Deaf/Hard-of-hearing	Additional Populations: • Blind/visually impaired should be included as an underserved population. Additional Service Needs: • Mandatory tutoring for our deaf school children. Additional Comments: • I would like to see DMH acknowledge that the Deaf/Hard-of-hearing population is underserved, and therefore aim to identify priorities and strategies within that assumption. I'd also like to be able to vote on/identify priorities for more than two priority age groups. • Ensure that "Underserved Cultural Populations" is inclusive of people with disabilities, especially Deaf/Hard-of-hearing, who cannot access traditional services due to communication, physical ability, and other barriers. • Directly include Deaf/Hard-of-hearing in DMH's definition of Underserved Cultural Populations. All our comments are related to being conducted within a defined population. • DMH needs to establish Standards and Protocols for accountability to provide ADA-accessible services. • The PEI reports that are being developed should have separate data for Deaf/Hard-of-hearing, not included in overall Underserved Cultural Populations reports. • All data regarding Deaf/Hard-of-hearing needs to be discussed and tabulated/graphed as its own distinct unit.
LGBTQ	Additional Populations: • Older adult LGBT population is often underserved due to staff priorities at senior centers. Many LGBT older adults do not have children and therefore might depend on community centers for support, especially ethnic minority LGBT seniors. • Victims of domestic violence and children exposed to domestic violence are trauma-exposed and in critical need of mental health PEI services. • It is important to cover as many Asian and Pacific Islander languages as possible. It is a very diverse group with few linguistic similarities. Additional Service Needs: • Have PEI strategies for domestic violence issues in all populations and age groups since it crosses all lines. • In schools, have identified safe people.

ADDITIONAL NEEDS OR POPULATIONS	
	• Safe housing for homeless youth. • Leadership programs to promote positive identity development. • Creation of speakers' bureau and marketing campaign on LGBTQ. • No HIV requirements for residential services, housing, or housing subsidies. • Create a DMH LGBTQ advisory board. • Programs to address stigma of aging and ageism on LGBTQ community and mental illness: isolation, internal homophobia, and co-occurring disorders. Additional Comments: • More consumer and family input is needed for the PEI process. No identified family reps in my group. I was only self-identified consumer rep organization. Need better outreach and access. Two family and consumer reps were turned down due to full registration. Perhaps slots registered for family and consumers should be held. • Not all spaces need to be non-descriptive because we don't want to reinforce fear or staying closeted. • Collect appropriate and accurate data, especially on transgender and Native Americans, for both TAY and Adults, so that it could be used to get funding to provide adequate services.
Countywide Health Plans	Additional Populations: • Priority groups do not represent those with mental/physical disabilities. Additional Service Needs: • Expansion of peer-to-peer support groups and self-help groups for at-risk individuals. • A transition program for parolees when they finish their sentences. • Train and hire peers to run the mental health programs. Additional Comments: • Hold a DMH-sponsored conference for the TAY age group and have speakers that TAY would respect and listen to. Get their opinion on what services would work best for them. • Integrate cost analyses to be able to determine which programs were effective.
Juvenile Justice	Additional Service Needs: • Access to mental health services for CYA youth who are on CYA parole. Currently, former CYA youth are often denied mental health services because they cannot bill. Additional Comments: • Categorize the different strategies according to prevention and early intervention criteria instead of lumping prevention and early intervention strategies together. • Participants wanted to be sure that all programs, interventions, and strategies be provided with culturally competent and representative personnel (i.e. clinicians, volunteers, etc).